

WEEKLY BULLETIN



CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH

ESTABLISHED APRIL 15, 1870
BERTRAM P. BROWN, M. D., Director

STATE BOARD OF PUBLIC HEALTH

DR. ELMER BELT, President
Los Angeles

DR. V. A. ROSSITER
Santa Ana

DR. F. M. POTTERER, SR., Vice-President
Los Angeles

DR. NORMAN F. SPRAGUE
Los Angeles

DR. BERTRAM P. BROWN, Executive Officer
San Francisco

DR. CHARLES E. SMITH
San Francisco

DR. HORACE L. DORMODY
Monterey

DR. JAMES F. RINEHART
San Francisco

ENTERED AS SECOND-CLASS MATTER FEB. 21, 1922, AT THE POST OFFICE AT SACRAMENTO, CALIFORNIA, UNDER THE ACT OF AUG. 24, 1912. ACCEPTANCE FOR MAILING AT THE SPECIAL RATE OF POSTAGE PROVIDED FOR IN SECTION 1103, ACT OF OCT. 3, 1917

SACRAMENTO, 631 J STREET, 2-4711

SAN FRANCISCO, 603 PHELAN BLDG., 760 MARKET ST., UN 8700

LOS ANGELES, STATE OFFICE BLDG., 217 W. FIRST ST., MA 1271

VOL. XXI, No. 45

NOVEMBER 28, 1942

GUY P. JONES
Editor

MALE INVESTIGATOR IN VENEREAL DISEASE CONTROL FOLLOW-UP

(Continued from last issue)

The correct functions of the male investigator in local health departments are as follows:

(1) His first responsibility is to secure for the health department dependable and accurate information concerning the contacts of infected military personnel. In most areas the investigator now goes directly into the army or navy hospitals and interviews the infected men in order to obtain the information concerning contacts. In some areas he assumes responsibility for completion of the morbidity card on each case.

In general, it has been found that these lay interrogators get more reliable and complete information than medical officers or corpsmen of the army or navy. There are perhaps several reasons for this. First, these lay investigators are more experienced and adept at obtaining the specific type of information desired. The constant turnover of medical corps personnel in any one military unit precludes the probability of continuous effective interviewing. This defect is being overcome in some camps where trained venereal disease control officers have been assigned. As such camps are prepared to take over the interviewing and the preparation of the epidemiologic forms we request the investigator has in some instances relinquished this work. There is a second reason why the lay investigator may meet with more success than even the trained army medical officer. The service men are less reticent about telling the whole story to the lay investigator than to some one attached to their own organization. Furthermore, the lay investigator is more familiar with the geography and the conditions in the neighboring communities than is possible for the army or navy medical

staff. This gives him an advantage in piecing together information that will be of value in tracing the contacts.

(2) The second function of the investigator is to do the follow-up on the contacts named by the military personnel. He first clears with the local health department files to determine if any of these are cases of record. If not, he proceeds with the field work. If the contacts named are outside of his jurisdiction he sees to it that the reports are immediately forwarded to the correct agency. If there is an emergency he may telephone or wire the information. It is thus seen that in general the investigator is responsible for following through on all epidemiologic work on contacts reported from any of the military agencies.

(3) As a third function the investigator does the greater part of the field work required on selectees reported by the State Health Department as having positive serologic tests for syphilis. The public health nurse or a clerk working under the direction of the public health nurse carries this phase of the work as far as possible by correspondence or telephone and in general whatever field work that is necessary is done by the investigator.

(4) The usual policy is for the male investigator to do the epidemiologic work involving contacts reported by clinic patients and from private physicians where the contact is alleged to be a prostitute.

(5) He does the follow-up work out of the clinics on the prostitute class and on other patients residing in certain so-called skid-row areas of the cities.

(6) He serves as the liaison officer on detail matters between the health department and each of the

following: the military units, the police department, the sheriff's office, the district attorney, the liquor control agencies, the courts, and the Federal Bureau of Investigation. In other words, he represents the venereal disease control officer in the detail matters with military agencies and law enforcement agencies.

(7) If time permits he may participate in the venereal disease educational program such as tacking up signs and posters, showing motion pictures, lecturing to industrial workers, etc.

Relationship of the Work of the Male Investigator and the Public Health Nurse

The work of the investigator and the public health nurse doing full time venereal disease control work are closely integrated. In general the public health nurse takes care of all clinic interviews including clinic social service. She also does the field work on contacts and lapses from the clinic except as noted above. She does the follow-up on contacts and lapsed cases reported by private physicians not involving prostitutes. She delegates venereal disease epidemiologic work to district public health nurses and turns over to the investigator such work (out of the clinic) as was noted above. She also carries on educational work among the health department staff and in the community.

While the public health nurse and investigator cooperate closely in their work it has been our experience that the investigator functions best if he is responsible administratively directly to the venereal disease control officer or the health officer rather than to the public health nurse. This means that in most instances there is no centralization of responsibility for the epidemiologic work in the public health nursing service.

This is the general administrative pattern and plan of division of work between the investigator and the public health nursing service; however, it should be understood that there may be some variation in detail among the various local health departments.

Reporting of Activities

Like the evolution of the investigators' functions the method of reporting his activities has been gradually evolved. Initially he reported in daily log form. This gave way to reporting activities by checking central tabulating unit punch cards supplemented by brief monthly narrative reports. This month the punch cards have been superceded by central registry epidemiologic forms that are completed on each contact named. Copies of every such report reaches the central registry where activity reports are compiled. The monthly narrative report is still required. This provides a brief resume of current activities and

trends from all areas of the State. Any new developments or procedures are noted. These reports are directed to the local control officer with a copy going to the State bureau office.

Place of the Investigator in the Program

It is our concept that in this war period the male investigator occupies a strategic position in the venereal disease control program. He interviews the commandant and the medical officers and the military police and the infected men about the military establishment. If he is clever and resourceful, he soon has the full confidence of the military establishment and is given full freedom to the cantonment area and complete cooperation of all personnel. If he is discourteous, indiscreet, or brazen he is soon shut out and all the regulations the Secretary of War or the Navy Department could issue would not help. He is also the key person in the cooperation between the police and health departments. He keeps the police advised of alleged foci of infection and follows through on assuring health department cooperation in the quarantine and examination of all police cases. He frequently serves as the liaison officer between the health department and the court offering testimony, explaining to the court the public health reasons for the various actions of the health department.

From this discussion the impression may be gathered that the male investigator is assuming the prerogatives of the venereal disease control officer. This is not the case. With the thinning out of our medical personnel more and more of the routine administrative problems must be delegated. The medical time and talent must be retained for jobs that only the doctor can do. A good male investigator can be the control officer's right arm in this wartime program.

You undoubtedly appreciate that we are now facing serious problems in maintaining this phase of our program intact. I have already indicated that four of our trained and experienced men have been called into military duty. At least an additional 10 are under 45 years of age and are now classed as 3A under Selective Service and are subject to call within the next few months. How we shall be able to maintain an adequate staff in the face of the competition from the military, the shipbuilding plants, aircraft factories, etc., is a problem we are now facing.

Summary

1. Five years experience with the use of the male investigator in venereal disease control follow-up has been briefly reviewed.
2. The qualifications desired and procedures used in the selection of this personnel have been given.

3. The functions and administrative relationship to other health department personnel were discussed.
4. The value of such personnel in the program has been indicated.

DIPHTHERIA CONTROL MUST BE MAINTAINED

The remarkable results achieved in the reduction of diphtheria morbidity and mortality in California are outstanding. In 1920, 5,822 cases of this disease with 451 deaths occurred in California. In 1941, there were but 763 reported cases with 59 deaths. From the first of this year through November 7, 668 cases have been reported, and during the first four months of the year 30 deaths have occurred. There are indications, in some sections of California, that more cases and more deaths from this disease are now occurring, and it is of the greatest importance that health officers throughout the State exert every effort to secure the immunization of all children who have not received this proved protection.

It is probable that the increase is due to the large influx into the State of children of industrial workers who have not been immunized against diphtheria in the States whence they have come. Health officers in those districts where the war industries have sprung up must recognize the importance of diphtheria control in their communities, and it is urged that special efforts be exerted to keep diphtheria within bounds.

It is believed that in most of the cities and counties that maintain full-time health services, adequate control measures are maintained at all times in the resident population. Children recently arrived in these communities should be discovered early and immunization against both diphtheria and smallpox should be offered without delay. The following table gives the numbers of cases and deaths from diphtheria from 1920 through 1941:

Year	Cases	Deaths
1920	5,822	451
1921	9,464	644
1922	8,708	599
1923	9,535	640
1924	11,109	695
1925	5,596	266
1926	6,114	291
1927	6,411	306
1928	4,743	273
1929	3,025	185
1930	3,071	193
1931	3,421	175
1932	3,201	207
1933	2,176	116
1934	1,972	107
1935	2,112	133
1936	2,010	126
1937	1,539	107
1938	1,615	98
1939	1,314	59
1940	893	75
1941	763	59

REVISED LIST OF REPORTABLE DISEASES

Reportable Only:

Anthrax
 Botulism—if commercial product notify State Department of Health at once.
 Coccidioidal Granuloma
 Dengue—keep patient in mosquito-free room.
 Epilepsy
 Food Poisoning
 Glanders—report by phone or telegraph.
 Jaundice—infectious or epidemic types.
 Malaria—keep patient in mosquito-free room.
 Pneumonia—specify type of pneumococcus if known.
 Relapsing Fever
 Rheumatic Fever
 Rocky Mountain Spotted Fever
 Tetanus
 Trichinosis
 Tularemia
 Undulant Fever

Reportable and Subject to Isolation:

Epidemic diarrhea of the newborn (in institutions)
 Chickenpox
 Dysentery—Amoebic
 Dysentery—Bacillary—specify type if known.
 German Measles
 Influenza
 Measles
 Mumps
 Ophthalmia Neonatorum
 Psittacosis
 Rabies—in animals. Use special card.
 Rabies—in humans.
 Septic Sore Throat (in epidemic form).
 Trachoma
 Tuberculosis—use special card.
 Whooping Cough
 Syphilis—use special card.
 Gonorrhea—use special card.
 Chancroid—use special card.
 Lymphopathia Venereum—use special card.
 Granuloma—Inguinale—use special card.

Reportable and Subject to Quarantine and Placarding:

Cholera—report by telephone or telegraph to State Department of Health.
 Diphtheria
 Encephalitis (Infectious)—specify type if known.
 NOTE: This means all forms of acute encephalitis such as St. Louis type, equine type, and any other epidemic form occurring in California.

Leprosy
 Meningitis (due to the meningococcus).
 Paratyphoid Fever—specify type A or B.
 Plague—report by telephone or telegraph to State Department of Health.

REVISED LIST OF REPORTABLE DISEASES—Continued

Acute Anterior Poliomyelitis
 Scarlet Fever
 Smallpox
 Typhoid Fever
 Typhus Fever
 Yellow Fever—report by telephone or telegraph to State Department of Health.

MORBIDITY*

Complete Reports for Certain Diseases Recorded for Week Ending November 21, 1942

Chickenpox

512 cases from the following counties: Alameda 26, Butte 2, Colusa 8, Contra Costa 12, Fresno 19, Humboldt 15, Kern 12, Kings 2, Lassen 3, Los Angeles 97, Madera 2, Marin 8, Mendocino 1, Merced 1, Monterey 7, Napa 13, Orange 16, Riverside 15, Sacramento 21, San Bernardino 10, San Diego 53, San Francisco 34, San Joaquin 22, San Luis Obispo 1, San Mateo 7, Santa Barbara 3, Santa Clara 38, Santa Cruz 3, Solano 13, Sonoma 9, Stanislaus 17, Sutter 7, Tehama 7, Ventura 1, Yolo 7.

German Measles

41 cases from the following counties: Alameda 3, Butte 1, El Dorado 1, Inyo 1, Los Angeles 13, Madera 1, Orange 3, San Diego 3, San Francisco 5, San Joaquin 1, San Mateo 1, Santa Clara 3, Shasta 1, Sonoma 4.

Measles

43 cases from the following counties: Alameda 3, Humboldt 1, Los Angeles 10, Mendocino 2, Napa 1, Orange 1, Sacramento 2, San Bernardino 2, San Diego 1, San Francisco 9, San Mateo 2, Santa Cruz 2, Shasta 1, Solano 2, Sonoma 3, Yolo 1.

Mumps

401 cases from the following counties: Alameda 32, Contra Costa 4, Fresno 8, Humboldt 40, Kern 3, Los Angeles 126, Madera 2, Marin 1, Monterey 1, Orange 8, Riverside 13, Sacramento 2, San Bernardino 8, San Diego 32, San Francisco 46, San Joaquin 39, San Mateo 3, Santa Clara 19, Santa Cruz 1, Solano 1, Sonoma 2, Stanislaus 4, Ventura 3, Yolo 3.

Scarlet Fever

165 cases from the following counties: Alameda 10, Amador 1, Butte 1, Fresno 3, Kern 5, Lassen 19, Los Angeles 58, Marin 1, Monterey 2, Orange 14, Sacramento 4, San Bernardino 5, San Diego 16, San Francisco 5, San Joaquin 1, Santa Barbara 1, Santa Clara 12, Solano 3, Stanislaus 1, Ventura 1, Yuba 2.

Whooping Cough

270 cases from the following counties: Alameda 46, Colusa 1, Fresno 5, Humboldt 3, Kern 3, Los Angeles 88, Marin 4, Mendocino 1, Orange 18, Sacramento 4, San Bernardino 3, San Diego 22, San Francisco 10, San Joaquin 5, San Luis Obispo 6, Santa Clara 5, Sonoma 4, Stanislaus 23, Sutter 5, Tehama 5, Ventura 9.

Diphtheria

27 cases from the following counties: Alameda 1, Kern 1, Los Angeles 4, Napa 6, Orange 1, Sacramento 3, San Bernardino 4, San Francisco 1, San Joaquin 2, Santa Clara 2, Solano 1, Yolo 1.

Epilepsy

48 cases from the following counties: Alameda 2, Fresno 4, Los Angeles 36, Riverside 1, San Bernardino 3, San Francisco 2.

Coccidioidal Granuloma

One case from San Joaquin County.

Dysentery (Bacillary)

8 cases from the following counties: Los Angeles 7, Monterey 1.

Food Poisoning

One case from San Francisco.

Influenza (Epidemic)

36 cases reported in the State.

* Data regarding the other reportable diseases not listed herein, may be obtained upon request.

Jaundice (Infectious)

2 cases from the following counties: Riverside 1, San Diego 1.

Meningitis (Meningococcic)

6 cases from the following counties: Alameda 1, Los Angeles 2, Sacramento 1, San Diego 1, San Francisco 1.

Pneumonia (Infectious)

59 cases reported in the State.

Poliomyelitis (Acute Anterior)

23 cases from the following counties: Alameda 1, Fresno 1, Los Angeles 19, Orange 1, San Diego 1.

Rabies (Animal)

3 cases from the following counties: Fresno 1, Los Angeles 2.

Rheumatic Fever

One case from Orange County.

Tetanus

2 cases from the following counties: Alameda 1, Los Angeles 1.

Trichinosis

One case from Kings County.

Tularemia

2 cases from San Bernardino County.

Typhoid Fever

4 cases from the following counties: Sacramento 1, Yolo 1, California 2.**

Typhus Fever

One case from Los Angeles County.

** Cases charged to "California" represent patients ill before entering the State or those who contracted their illness traveling about the State throughout the incubation period of the disease. These cases are not chargeable to any one locality.

Here's to the stork,
 A benevolent bird,
 That inhabits the residence districts.
 He doesn't sing tunes
 Nor yield any plumes
 But he helps out the vital statistics.

What an exciting super-tomorrow it will be!
 Americans are today making the greatest scientific developments in our history. That is a promise of new levels of employment, industrial activity and human happiness.—Clarence Francis.

University of California
 Medical Library
 3rd & Parnassus Aves
 San Francisco, Calif.

